STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120231-001**

Priority Health Insurance Company
Respondent

Issued and entered
this 14th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 24, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On March 31, 2011, after a preliminary review the Commissioner accepted the request for review.

The Commissioner notified the Priority Health Insurance Company (PHIC) of the external review and requested the information it used to make its final adverse determination. The Commissioner received PHIC's response on April 6, 2011.

The issue here can be decided by applying the terms of the Petitioner's insurance contract. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits under a group plan underwritten by PHIC. His benefits are defined in PHIC's *Insurance Policy* (the policy). The plan covers services from both network and non-network providers. Generally, services from network providers have the lowest out-of-pocket cost.

On May 7 and November 8, 2010, the Petitioner received routine care at the office of his family physician XXXXX, M.D. Dr. XXXXX is not in PHIC's provider network. PHIC

covered the visits as non-network benefits and applied the allowed fees for the visits ($105.00 and $115.00, respectively) to the Petitioner's non-network deductible.

The Petitioner appealed PHIC's decision to treat the office visits as non-network benefits. At the conclusion of its internal grievance process, PHIC issued a final adverse determination dated February 15, 2011, upholding its original decision.

III. ISSUE

Did PHIC correctly process the claims for the Petitioner's May 7 and November 8, 2010, office visits as non-network benefits?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that PHIC is not honoring this notice in its "welcome packet" that indicated that certain services would not be subject to a deductible:

> Priority Health wants to help you be healthier. And we want to help you find medical problems early, so you can deal with them before they become big health problems. That's why you're covered for routine physicals, well-child visits, immunizations, prenatal care, mammograms and more without paying your deductible.

During his grievance appeal, the Petitioner indicated that PHIC should provide network level coverage for care from Dr. XXXXX because it is not the Petitioner's fault that Dr. XXXXX is not in PHIC's network.

Respondent's Argument

In its final adverse determination, PHIC explained that "claims are processed based on the provider's participation status, regardless of the circumstance." The policy has the following provisions (pp. 33 and 36) that support PHIC's decision:

> **SECTION 6. Limitations**
>
> To receive Network benefits, you may only receive services from a Network Provider.
>
> *** * ***
>
> **SECTION 8. Claims Provisions**
>
> *** * ***
>
> Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level. . . .

Since Dr. XXXXX is not a network provider, PHIC argues it properly processed the claims for his services as non-network benefits and applied the allowed fees to the Petitioner's out-of-network deductible.

Commissioner's Review

The Petitioner states he is "loyal" to Dr. XXXXX, his long-time family physician whose office is less than one mile from his home. He wants to continue to see Dr. XXXXX and have the care covered as if it was from a network provider and thus subject to less out-of-pocket expense. Unfortunately, the terms of the policy do not require such an exception.

The Petitioner does not dispute the fact that Dr. XXXXX is not part of PHIC's network. The Petitioner also does not dispute the fact that non-network services are subject to an annual individual deductible of $4,000, nor the fact that his non-network deductible for 2010 had not been satisfied at the time he received services from Dr. XXXXX. Therefore, the Commissioner concludes that PHIC correctly processed the claims from Dr. XXXXX and applied the allowed fees to the deductible.

The Petitioner submitted a page from a document he described as a "welcome packet" to support his contention that no deductible should apply to Dr. XXXXX's services. Without the full document, the Commissioner cannot conclude that the Petitioner was misinformed. But even more importantly, the terms and conditions of the Petitioner's coverage are found in the policy, not in any promotional or supplementary material. The policy's schedule of benefits is clear that the non-network deductible is applied to both non-network office visits and preventive health services as shown in the following chart:

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services	• 100% Coverage • Office visit Copayment may apply	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
PHYSICIAN SERVICES		
Office and Home Visits (Evaluation and management services only)	• $30.00 Copayment per Primary Care visit • $45.00 Copayment per Specialty Care visit • Prescription drug Copayment may also apply when selected injectable drugs are provided	• 60% Coverage of Reasonable and Customary Charges • Deductible applies • Prescription drug Copayment may also apply when selected injectable drugs are provided • Amounts paid after Deductible do apply toward Out-of-Pocket Maximums

Therefore, the Commissioner concludes and finds that PHIC properly processed the claims for Dr. XXXXX's services as non-network benefits under the terms of the policy.

V. ORDER

The Commissioner upholds PHIC's final adverse determination of February 15, 2011. PHIC is not required to pay in-network level benefits for the Petitioner's May 7 and November 8, 2010, office visits.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner